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ABSTRACT

The assessment process can be integrated with treatment and evaluation for helping teenage suicide attempters and families in short term psychiatric hospitalization programs. The method is an extremely efficient way for the therapist to work within a given time constraint. During family assessment sufficient information can be gathered to accommodate hospital record demands; targeted family problems can be treated; and treatment effectiveness can be evaluated. In assessment a genogram can be drawn which will satisfy hospital requirements for family assessment. Many types of family treatment can be utilized for integration with assessment. Three types of therapy include structural, communication, and psychodynamic. Assessment and treatment can be integrated so that the clinician can not only get information for hopsital records but can treat targeted family problems. Assessment alone would include the eliciting of information about family structure, family health, or family interaction. By asking simple questions and making interpretations, assessment can become family treatment. This method of assessment/treatment was evaluated with a teenage suicide attempter and her mother. It was determined that the lack of open communication between mother and daughter was the single most important factor leading to the suicide attempt. A single case design was used to evaluate the method. Assessment integrated with treatment strategies took place triweekly. Results showed a significant increase of open communication between mother and daughter and no repeat of suicidal behavior for 3 years after hospitalization. (ABL)

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Family Assessment/Treatment/Evaluation Methods Integrated for Helping Teen Suicide Attempters/Families in Short Term Psychiatric Hospitalization Programs

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Family Assessment/Treatment/Evaluative Methods Integrated
for Helping Teen Suicide Attempters/Families in Short Term
Psychiatric Hospitalization Programs

By Suzanne Shepard

This paper demonstrates how the **assessment** process can be integrated with **treatment** and **evaluation**. The method is an extremely efficient way for the therapist to work within a given time constraint. During family assessment, 1) sufficient information can be gathered to accommodate hospital record demands, 2) targeted family problems may be treated and 3) treatment effectiveness evaluated. First, short definitions are given for assessment and treatment. Second, an explanation is given on integrating assessment and treatment. Third, the assessment/treatment method is evaluated in a single case study.

Assessment: For the purpose of this paper, the assessment tool chosen is the genogram. The genogram is a picture of a family tree that includes written information about family members and their relationships over at least three generations (McGoldrick and Gerson, 1985). The therapist and family draw the genogram together. The information written on the genogram relates to family structure (i.e. names, birth dates, type of relationships of persons in the home, occupations); family health (i.e. mental and physical health, abuse, substance use); and family interaction (i.e. descriptions of interactions between family members including emotional bonds, conflict, closeness, life events leading to the suicide attempt). The therapist can use this information to satisfy hospital requirements for family assessment. Usually, this method of gathering information is thought of as only assessment and not treatment.

Treatment: Many types of family treatment can untilized for integration with assessment, however for this paper only three will be defined: structural, communication and psychodynamic. The following is a brief explanation of these three types of therapy,

Structural. Structural theorists postulate that the family system carries out its functions through subsystems such as the parent/child dyad. The child finds security in

this subsystem. When parents divorce, the child may mourn the "structure that was lost" (Minuchin, 1984, p. 71). The teen may be asked to take over the role of the lost parent and consequently adopt suicidal behaviors in order to communicate an inability to carry on with this role. The goal of therapy would be to establish a different family hierarchy and boundaries which would allow the teen to escape this role.

Communication. Communication theorist Virginia Satir (1972) posits that symptoms arise when family communication content is not congruent with real issues or when communication is misinterpreted by the recipient. The goal of therapy is to open the lines of communication and enable family members to understand and communicate the real issues.

Psychodynamic. A key goal of psychodynamic therapy is differentiation between family members of present and past generations. The psychodynamic theorist hypothesizes that there is an emotional/behavioral projection process within generations of families. Understanding suicidal behavior would require members to look carefully at past conscious and unconscious emotional relationships/behaviors projected onto other family members. Family members would be helped to differentiate between other family members, by learning to appreciate each others feelings and developing behaviors which more effectively support these feelings (Bowen, 1978).

Integrating assessment and treatment: Assessment and treatment can be integrated so that the clinician can, not only get information for hospital records, but treat targeted family problems. Assessment alone would include the eliciting of information about family structure, family health or family interaction. By asking simple questions and making interpretations, assessment can become family treatment. For instance, while assessing family structure, the therapist can also do a simple structural family intervention. Family health assessment can include components of communication therapy and family interaction assessment could include some psychodynamic interventions. The following are examples of these combinations.

Family structure assessment/structural family treatment: To assess family structure for hospital records, the therapist asks about the loss of family members through death, divorce and separation. The teen may reply that the father and mother have recently divorced and the father is no longer living in the home. Using a structural intervention, the therapist could ask how that divorce impacted the family hierarchy. Each member is solicited for an answer. The teen may indicate a loss of support and resentment towards having to care for the mother who may be clinically depressed or an alcoholic. The therapist and family outline directives for realigning the family hierarchy and getting the teen out of the supportive role.

Family health assessment/communication family treatment. In order to assess family health, the therapist might ask if any of the family members are alcoholics. The prevalence of alcoholism would be noted on the genogram. To integrate a communication intervention with the assessment, the therapist could ask what behaviors are associated with the alcoholism. The alcoholism could manifest itself as parental verbal abuse of the teen. The teen could discover through this interchange that the verbal abuse (i.e. name calling, blaming) is more an issue of chronic parental alcoholism than what he thought was an issue of whether not he was a good person. The assessment process becomes a forum in which family issues are more clearly defined and in this case better communication skills are learned and practiced.

Family interaction assessment/psychodynamic family treatment. Family interactions are recorded on the genogram. For instance, conflictual relationships are noted by jagged lines between conflicting family members. The therapist may point out intergenerational patterns such as a history of mothers and daughters not being close (warm/loving) to each other. In this case, the mother and daughter would be shown how their past generations of mothers and daughters have not gotten along and that these feelings get translated into cutoffs between family members, lack of emotional support,

loneliness and subsequent suicidal behavior. Alternative, more supportive methods of relating could be briefly discussed.

Evaluation: This method of assessment/treatment was evaluated with a teen suicide attempter and her mother. A fourteen year old female was admitted to a short term psychiatric hospital. The teen's presenting problem was a serious overdose of drugs and intent to die. Family assessment was scheduled for six one hour sessions with the mother and daughter. During the initial interview, the mother and daughter determined that the lack of open communication was the single most important factor leading to the suicide attempt. Open communication was operationalized as expression (to listen and respond without interruption or physical/verbal retaliation) and content (the ability to know accurately what a person is thinking, feeling and experiencing).

A single case design was used to evaluate the assessment/treatment method. The dependent variable was open communication and the independent variable was the experience of assessment. The hypothesis was that the experience of assessment would influence the degree of family open communication. A baseline was measured by the Olson, McCubbin, Barnes, et. al. (1985) Parent Adolescent Communication Inventory and a Likert, self-anchored nine point scale (1 - no communication/silent treatment, 5 - moderately open, some verbal and 9 - open communication/able to listen, respond and know what each other is thinking). The dependent variable was continually monitored during assessment.

Assessment integrated with treatment strategies took place triweekly. Results showed a significant increase of open communication between mother and daughter and no repeat of the suicidal behavior for three years after hospitalization. Internal and external validity was jeopardized by the fact that other treatment modalities were being implemented in the hospital treatment program and no control was utilized. However, the family sessions could have made a unique contribution, because the mother/daughter contact was limited only to the family assessment sessions.

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